

## Model Continuation Coverage Election Notice for Pennsylvania Mini-COBRA Coverage

Date of Notice:

Dear: \_\_\_\_\_  
(Beneficiary Names or Status)

**This notice contains important information about your right to continue your health care coverage in the [enter name of group health plan] (the Plan). This notice also contains important information about other health coverage options that may be available to you, including coverage through Pennie®. You may be able to get coverage through Pennie® that costs less than Mini-COBRA continuation coverage. Please read the information contained in this notice very carefully.**

To elect continuation coverage, follow the instructions on the following pages to complete the enclosed Continuation Coverage Election Form and submit it to us.

### Why am I getting this notice?

Your coverage under the Plan will end on \_\_\_/\_\_\_/\_\_\_ due to below noted reason: if you do not elect continuation coverage,

- End of employment
  - Involuntary
  - Voluntary
- Divorce or legal separation
- Death of employee
- Entitlement to Medicare
- Reduction in hours of employment
- Loss of dependent child status
- Bankruptcy of employer

Under Pennsylvania law, you are entitled to elect Mini-COBRA continuation coverage, which will continue group health care coverage under the Plan for up to nine (9) months.

### Who is qualified to get Mini-COBRA continuation coverage?

This coverage is available to:

- Employee or former employee
- Spouse or former spouse
- Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, continuation coverage will begin on \_\_\_/\_\_\_/\_\_\_ and can last until \_\_\_/\_\_\_/\_\_\_.

**Are there other coverage options besides Mini-COBRA continuation coverage?**

Yes. Instead of enrolling in Mini-COBRA, there may be more affordable coverage options for you and your family through Pennie® at [www.pennie.com](http://www.pennie.com), Pennsylvania’s health insurance marketplace; CHIP at <https://www.dhs.pa.gov/CHIP/>; Medicaid at <https://www.dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx>; Medicare at <https://www.medicare.gov/>; or other group health plan coverage options (such as a spouse’s plan). Some of these options may cost less than Mini-COBRA.

It is important that you choose carefully. Once you select Mini-COBRA, unless an exception applies, you may only switch to Pennie® coverage during the Open Enrollment Period, typically between November 1 and December 15. There are two exceptions when you would be eligible for a Special Enrollment Period for Pennie® coverage. First, if your Mini-COBRA costs change, such as if your former employer stops contributing to your premium, you may have a Special Enrollment Period. Second, if your nine months of Mini-COBRA coverage ends after Pennie®’s Open Enrollment Period, you are eligible for a Special Enrollment Period.

**If I elect Mini-COBRA continuation coverage, when will my coverage begin and how long will the coverage last?**

Mini-COBRA coverage will begin on [*enter date*], and will extend until [*insert date*]. Mini-COBRA continuation coverage may end before that date if an enrollee becomes eligible for Medicare or another employer’s coverage, or fails to pay premiums on a timely basis, or if the group policy is terminated. It may also end early if the enrollee switches to coverage through Pennie® during an Open Enrollment Period.

**How much will Mini-COBRA coverage cost?**

Continuation coverage will cost: \$ \_\_\_\_\_ for each of the nine months of Mini-COBRA continuation coverage.

This amount is the cost each qualified enrollee will be required to pay for each option, per month of coverage and any other permitted coverage periods. This amount may not be more than 105% of the group rate of the insurance being continued on the due date of each payment.

You do not have to send any payment with the Election Form. Important additional information about payment for continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to Mini-COBRA continuation coverage, you should contact

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Where can I find more information about Mini-COBRA and my options?**

The Pennsylvania Insurance Department has additional information to help you understand your options available at: <https://www.insurance.pa.gov/Coverage/health-insurance/COBRA/Pages/Mini-COBRA>.

**Mini-COBRA Continuation Coverage Election Form**

**Instructions:** To elect Mini-COBRA continuation coverage, complete this Election Form and return it to us. Under Pennsylvania law, you have thirty (30) days after the date of this notice to decide whether you want to elect continuation coverage.

Send completed Election Form to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

This Election Form must be completed and returned by \_\_/\_\_/\_\_\_\_ via \_\_\_\_\_.  
If mailed, it must be post-marked no later than \_\_/\_\_/\_\_\_\_\_.

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect continuation coverage. If you reject continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect continuation coverage in the [*enter name of plan*] (the Plan) as indicated below:

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
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a. \_\_\_\_\_

b. \_\_\_\_\_

c. \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to individual(s) listed above

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Print Address

\_\_\_\_\_

Telephone number

## **Important Information about Your Mini-COBRA Continuation Coverage Rights**

### **What is Mini-COBRA continuation coverage?**

Pennsylvania law requires this group health insurance coverage give employees and their families the opportunity to continue their coverage for up to nine months when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, covered employees and eligible dependents may include the employee (or retired employee) covered under the group health plan, the covered employee’s spouse and the dependent children of the covered employee.

Mini-COBRA continuation coverage is the same coverage, with no break in coverage, that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

### **Who is eligible for Mini-COBRA continuation coverage?**

Employees and eligible dependents who have been continuously insured under the group policy or for similar benefits under any group policy which it replaced, for the three consecutive months ending with the employee’s termination by a qualifying event. (For example, if an employer changes the group policy within that three-month period, and the employee was covered under the old policy and the replacement policy over the course of the three-month period, the employee or eligible dependent would still be eligible for Mini-COBRA coverage.) Continuation coverage is not available if:

(1) the employee or eligible dependent is eligible for coverage under Medicare;

(2) the employee or eligible dependent fails to verify that they are ineligible for employer-based group health insurance as an eligible dependent;

or

(3) the employee or eligible dependent is or could be covered by any other insured or uninsured arrangements that provides hospital, surgical or major medical coverage for individuals in a group and under which the person was not covered immediately prior to the termination of the employee’s group coverage. . (This does not include Medical Assistance, also known as Medicaid, or CHIP, the Children’s Health Insurance Program. If a person is eligible for either of those programs, but not enrolled, that does not prevent them from being eligible for Mini-COBRA.)

### **How long will Mini-COBRA continuation coverage last?**

Coverage may be continued under the Mini-COBRA law for up to nine (9) months. However, coverage will end if any of these events happens after continuation coverage has begun:

- If an enrollee in Mini-COBRA coverage becomes eligible for Medicare.
- If an enrollee in Mini-COBRA coverage becomes eligible for another employer’s coverage.
- If an enrollee fails to pay premiums on a timely basis.
- If the group policy is terminated.
- The enrollee switches to coverage through Pennie® during Pennie®’s Open Enrollment Period.

If eligibility for coverage ends, the employee or eligible dependent is required to provide written notice to the administrator within fourteen (14) days that coverage should not occur.

### **How can you elect continuation coverage?**

To elect continuation coverage, each covered employee or eligible dependent must complete the Continuation Coverage Election Form and furnish it according to the directions on the Form. Unless an eligible dependent's election otherwise specifies, election of continuation coverage by an eligible dependent will be deemed an election of continuation coverage on behalf of any other eligible dependent who would lose coverage by reason of the qualifying event.

In considering whether to elect continuation coverage, you should be aware that there is only a short time for making your choice for how you will get health care coverage. If you want to elect Mini-COBRA coverage, you (or your eligible dependent) must give notice to the administrator (who may be your employer) of your election within 30 days of receiving notice of the qualifying event.

Possibly sooner than that, only 30 days after your group health coverage ends because of the qualifying event listed above, your right to select two other options will expire: special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer); and your Special Enrollment Period for Pennie<sup>®</sup> coverage.

### **How much does continuation coverage cost?**

Continuation coverage will cost: \$ \_\_\_\_\_ for each of the nine months of Mini-COBRA continuation coverage.

This amount is the cost each qualified enrollee will be required to pay for each option, per month of coverage and any other permitted coverage periods. This amount may not be more than 105% of the group rate of the insurance being continued on the due date of each payment.

**\*Note:** You do not have to send any payment with the Election Form.

### **When and how must payment for continuation coverage be made?**

*[Insert information regarding the requirements related to payment for continuation coverage, including any periodic payment provisions or permissible grace periods.]*

You may contact \_\_\_\_\_  
\_\_\_\_\_ to confirm the correct amount of your first payment or to discuss payment issues.

Your payment(s) for continuation coverage should be sent to:

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**For more information**

This notice does not fully describe continuation coverage or other rights with respect to your coverage.

More information is available from:

\_\_\_\_\_.

If you have any questions concerning the information in this notice, your rights to coverage you should contact:

\_\_\_\_\_.

For more information about your rights under state law, contact:

Pennsylvania Insurance Department

By Phone: 1-877-881-6388

By E-mail: [ra-in-consumer@pa.gov](mailto:ra-in-consumer@pa.gov)

### **Keep Your Administrator Informed of Address Changes**

In order to protect your and your family's rights, you should keep the below party informed of any changes in your address and the addresses of family members.

\_\_\_\_\_

You should also keep a copy, for your records, of any notices you send to \_\_\_\_\_

\_\_\_\_\_.